Commonwealth of Kentucky
Cabinet for Health and Family Services
Department for Medicaid Services

The MAP 351A Form

The MAP 351A is to be used by Home and Community Based Waiver, Adult Day Health Care and Model Waiver II providers. The MAP 351A is designed to be a complete and thorough assessment of the patient that:

1. Can be used by the Peer Review Organization (PRO) to determine and validate the level of care and the appropriateness of services to be prior-authorized; and

2. Assists the providers in developing an appropriate plan of care.

General Information Regarding the MAP 351A

- The MAP 351A is to be used by waiver providers as an assessment document and shall be completed by the assessment team at each certification, recertification, and reapplication. Once completed, the MAP 351A is to be forwarded to the PRO for level of care validation and supporting documentation in determining the appropriateness of services to be prior-authorized.

- Throughout the form there are "Comments sections" to provide the PRO with a better understanding of the applicant/member's difficulty. These entries serve as supporting documentation.

- Provide the applicant's name (last, first) and Medicaid Identification Number (Social Security number for individuals whose eligibility is pending) in the appropriate spaces at the top of each page.

- Completion and submittal of pages one (1) through eleven (11) are **not** necessary when requesting a modification/amendment. Items 4-5 on page twelve (12) are the only sections to be completed and submitted when requesting a modification/amendment.

- It is imperative that all questions be answered in their entirety. Failure to complete the form clearly and accurately will result in the return of the form to the waiver provider.

Section Instructions for Completing the MAP 351A

Section I – Recipient Demographics

This section compiles the member's demographics. Answer each question, **do not** leave blank or enter "N/A".

Name

Enter the applicant/member's full name (Last, First, Middle).

Date of Birth

Enter the applicant/member's date of birth (MM/DD/YYYY).

Medicaid Number

Enter the ten (10) digit Kentucky Medical Assistance number found on the member's Medicaid identification card. If the applicant's Medicaid eligibility has not yet been determined, enter the individual's social security number.

Street Address

Enter the street address where the applicant/member resides.

County Code

Enter the three (3) digit county code of the applicant/member's residence.

Sex

Check the box corresponding with the applicant/member's gender.

Marital Status

Check the box corresponding with the applicant/member's current marital status.

City, State and zip code

Enter the city, state and zip code where the applicant/member resides.

Emergency Contact (name)

Enter the name of the person whom the member or his legal representative designates as the emergency contact for the applicant/member.

Emergency Contact (phone number)

Enter the phone number of the individual designated as the applicant/member's emergency contact

Recipient phone number

Enter the phone number of the applicant/member or a number where he/she may be contacted.

Is recipient able to read and write

Check the box corresponding with the appropriate answer.

Recipient's height

Enter the applicant/member's height in feet and inches.

Recipient's weight

Enter the applicant/member's weight in pounds.

Section II – Recipient Waiver Eligibility

This section compiles information regarding the applicant/member's waiver eligibility. Answer each question in this section, **do not** leave blank or enter "N/A".

Type of program applied for (check one)

Check the box that matches the waiver program for which the applicant/member is applying.

Type of Application

Check the box corresponding with the appropriate type of application for the completion of this MAP 351A.

"Initial application" refers to the applicant/member's first application into the waiver program.

"Re-application" refers to an applicant/member that was once enrolled in the waiver and was terminated. The member is now reapplying for waiver services.

"Re-certification" refers to the recertification of a waiver member to obtain approval for continuing or on-going care.

Recipient admitted from (check one)

Check the appropriate box that accurately reflects the applicant/member's current situation. If "other" is checked, please define.

Certification period

Enter the beginning and ending dates (MM/DD/YYYY) of the certification or recertification period.

Has applicant/recipient's freedom of choice been explained and verified by a signature on the MAP-350 Form

Check the box corresponding with the accurate answer.

Has recipient been informed of the process to make a complaint

The applicant/member must be informed of the proper procedures for filing complaints. Check the box matching the accurate answer.

Home and Community Based Waiver/Adult Day Health Care Members and Model Waiver II members may file a complaint by contacting the

Commonwealth of Kentucky, Office for Inspector General at 1-800-635-6290.

Physician's name

Enter the full name of the applicant/recipient's physician.

Physician's license number

Enter the five (5) digit license number of the applicant/member's physician.

Physician's phone number

Enter the phone number of the applicant/member's physician.

Enter recipient diagnosis(es)

Enter the member's medical/mental diagnosis(es) information requested in the order listed. Enter "none" in "secondary" and "others" only if there is not more than one diagnosis for the applicant/member.

Section III – Case Management Information

This section compiles the case management information. Answer each question, **do not** leave blank or enter "N/A"

Provider name

Enter the name of the case management provider.

Provider number

Enter the eight (8) digit provider number of the case management provider entered in the "Provider name" entry.

Provider phone number

Enter the case management provider's phone number.

Street Address

Enter the case management provider's street address.

City, state and zip code

Enter the case management provider's city, state and zip code.

Provider contact person

Enter the name of an individual with the case management provider who may be contacted if there are any questions regarding information contained on the MAP 351A.

NOTE: The designated individual must be familiar with the applicant/member and the information contained on the MAP 351A.

Section IV – Activities of Daily Living

This section compiles information regarding the applicant/member's ability to participate in daily living activities. There are eight (8) questions in this section. Read each question and check the appropriate answer. If the answer is "yes", proceed to the next question. If the answer is "no", select all of the appropriate supporting statements and provide detailed information in the "Comments" section of the form. Each question must be answered, **do not** leave blank or enter "N/A"

Example: Using the first question, "Is recipient able to dress independently" the assessment team determines that the individual is unable to dress himself and the team marks the answer "no". Upon reviewing the supporting statements and evaluating the individual, the team then marks "Requires total assistance". Since the team answered "no" to the question, details must be provided in the "Comments" section. The assessment teams writes "Due to recent stroke, patient is unable to raise arms to dress self --- requires total assistance" as supporting documentation.

1. Dress independently

   Check yes or no. If yes, proceed to question #2. If no, check the applicable, supporting statements and provide detailed information in the "Comments" section.

2. Groom independently

   Check yes or no. If yes, proceed to question #3. If no, check the applicable, supporting statements and provide detailed information in the "Comments" section.

3. Independent with bed mobility

   Check yes or no. If yes, proceed to question #4. If no, check the applicable, supporting statements and provide detailed information in the "Comments" section.

4. Independent with bathing

   Check yes or no. If yes, proceed to question #5. If no, check the applicable, supporting statements and provide detailed information in the "Comments" section.

5. Independent with toileting

Check yes or no. If yes, proceed to question #6. If no, check the applicable, supporting statements and provide detailed information in the "Comments" section.

6. Independent with eating

Check yes or no. If yes, proceed to question #7. If no, check the applicable, supporting statements and provide detailed information in the "Comments" section.

7. Independent with ambulation

Check yes or no. If yes, proceed to question #8. If no, check the applicable, supporting statements and provide detailed information in the "Comments" section.

8. Independent with transferring

Check yes or no. If yes, proceed to Section V. If no, check the applicable, supporting statements and provide detailed information in the "Comments" section.

Section V – Instrumental Activities of Daily Living

This section compiles information regarding the applicant/member's ability to perform complex tasks essential in community living. There are eight (8) questions in this section. Read each question and check the appropriate "yes" or "no" answer. If the answer is "yes", proceed to the next question. If the answer is "no", select all of the appropriate supporting statements and provide detailed information in the "Comments" section of the form. Each question must be answered, **do not** leave blank or enter "N/A".

Example: Question #6, "Is recipient able to obtain and take medication independently", the assessment team determines that the applicant/member is unable to do so and marks "no" on the form. Upon reviewing the supporting statements contained on the form, the team marks "Arranges for medication to be obtained and taken correctly". The assessment team writes, "The patient's daughter obtains medication on a monthly basis and arranges it in a medi-planner for her mother each week" as supporting documentation.

1. Meal preparation

   Check yes or no. If yes, proceed to question #2. If no, check the applicable, supporting statement and provide detailed information in the "Comments" section.

2. Independent shopping

   Check yes or no. If yes, proceed to question #3. If no, check the applicable, supporting statements and provide detailed information in the "Comments" section.

3. Light housekeeping

   Check yes or no. If yes, proceed to question #4. If no, check the applicable, supporting statements and provide detailed information in the "Comments" section.

4. Heavy housekeeping

   Check yes or no. If yes, proceed to question #5. If no, check the applicable, supporting statements and provide detailed information in the "Comments" section.

5. Laundry tasks

Check yes or no. If yes, proceed to question #6. If no, check the applicable, supporting statements and provide detailed information in the "Comments" section.

6. Obtaining and taking medication independently

Check yes or no. If yes, proceed to question #7. If no, check the applicable, supporting statements and provide detailed information in the "Comments" section.

7. Handling finances independently

Check yes or no. If yes, proceed to question #8. If no, check the applicable, supporting statements and provide detailed information in the "Comments" section.

8. Independent usage of telephone

Check yes or no. If yes, proceed to Section VI. If no, check the applicable, supporting statements and provide detailed information in the "Comments" section.

Section VI – Mental/Emotional

This section compiles information regarding the applicant/member's mental and emotional health. There are six (6) questions in this section. Read each question and check the appropriate answer. If required, select all of the appropriate supporting statements and provide detailed information in the "Comments" section of the form. Each question must be answered, **do not** leave blank or enter "N/A".

1. Behavior problems

   Check yes or no. If no, proceed to question #2. If yes, check the applicable, supporting statements and provide detailed information along with the frequency in the "Comments" section.

2. Recipient mental diagnosis

   Check yes or no. If no, proceed to question #3. If yes, check the applicable diagnosis and enter the date-of-onset. Provide detailed information in the "Comments" section.

3. Recipient orientation to person, place and time

   Check yes or no. If yes, proceed to question #4. If no, check the applicable statements and provide detailed information in the "Comments" section.

4. Major change or crisis

   Check yes or no. If no, proceed to question #5. If yes, provide detailed information in the "Description" section.

5. Social and/or community activities

   Check yes or no. If no, proceed to question #6. If yes, provide detailed information in the "Description" section.

6. Recipient history

   Check never, occasionally, often or always for each of the behaviors listed. **Do not** leave any of the items blank. Provide detailed information in the "Comments" section for each item that is marked occasionally, often or always.

Section VII – Clinical Information

This section compiles information regarding the applicant/member's clinical background. There are nineteen (19) questions in this section. Read each question and check the appropriate answer. If required, select all of the appropriate supporting statements and provide detailed information in the "Comments" section of the form. Each question must be answered, **do not** leave blank or enter "N/A"

1. Adequate vision

   Check yes or no. If yes, proceed to question #2. If no, check the applicable, supporting statements and provide detailed information in the "Comments" section.

2. Adequate hearing

   Check yes or no. If yes, proceed to question #3. If no, check the applicable, supporting statements and provide detailed information in the "Comments" section.

3. Communication needs

   Check yes or no. If yes, proceed to question #4. If no, check the applicable, supporting statements and provide detailed information in the "Comments" section.

4. Adequate diet

   Check yes or no. If yes, proceed to question #5. If no, check the applicable, supporting statements and provide detailed information in the "Comments" section. If "Tube feeding require" is checked, provide the brand, amount, and frequency in the "Comments" section.

5. Assistance with breathing

   Check yes or no. If no, proceed to question #6. If yes, check the applicable, supporting statements and provide as much detailed information as possible in the "Comments" section. The information in the "Comments" section is to include the status of the applicant/member's respiratory condition (i.e. stable, declining, weaning). If "Oxygen therapy" is checked, provide the liters per minute and deliver device in the "Comments" section. If "Ventilator" is checked list the settings in the "Comments" section.

6. History of stroke(s)

Check yes or no. If no, proceed to question #7. If yes, check the applicable, supporting statements and provide detailed information in the "Comments" section. If "Functional limitations" is checked, provide number of limbs affected in the "Comments" section.

7. Skin care

Check yes or no. If no, proceed to question #8. If yes, check the applicable, supporting statements and provide detailed information in the "Comments" section.

8. Routine lab work

Check yes or no. If no, proceed to question #9. If yes, provide details, including the type and frequency, in the "Comments" section.

9. Genital and/or urinary care

Check yes or no. If no, proceed to question #10. If yes, check the applicable, supporting statements and provide detailed information in the "Comments" section.

10. Physician ordered vital sign evaluation

This question refers to **physician** ordered vital sign evaluation (i.e. orthostatic blood pressure). Check yes or no. If no, proceed to question #11. If yes, provide detailed information in the "Comments" section including type of evaluation order by the physician and frequency.

11. Total or partial paralysis

Check yes or no. If no, proceed to question #12. If yes, provide detailed information in the "Comments" section including the limbs affected.

12. Changes in body position

Check yes or no. If no, proceed to question #13. If yes, check the applicable, supporting statements and provide detailed information in the "Comments" section.

13. 24 hour caregiver

Check yes or no and proceed to question #14.

14. Respite services

Check yes or no. If no, proceed to question #15. If yes, provide the frequency the service is required.

15. Intravenous fluids, IV medications or IV alimentation

Check yes or no. If no, proceed to question #16. If yes, check the supporting statements and provide the requested information, including the solution, location, amount, rate, frequency and prescribing physician.

16. Drug allergies

List any known drug allergies and type of reaction, if known (i.e. penicillin – hives). If there are no known allergies, enter “None”, “NKDA” or “NKA”.

17. Other allergies

List any other known allergies and type of reaction, if known (i.e. shellfish – respiratory distress or medical/surgical tape – blisters). If there are no other known allergies, enter “None” or “NKA”.

18. Medications

Check yes or no. If no, proceed to question #19. If yes, list each medication and provide the name of the medication, dosage/route/frequency and the name of the person who administers the medication (i.e. self, son, caregiver, RN, etc.). If more space is required, attach additional pages as needed.

19. Adaptive equipment

Check has, needs or N/A for each item listed. For items that are checked needs, provide details in the “Comments” section.

Section VIII – Environmental Information

This section compiles information regarding the applicant/member's physical environment. There are two (2) questions in this section. Each question must be answered, **do not** leave blank or enter "N/A".

1. Physical environment

   Check yes or no for each item listed. If no, provide detailed information in the "Comments" section when appropriate. For example, the item "Accessible" is checked "no". An appropriate comment may be "Patient's doorways are not wide enough to accommodate his wheelchair."

2. Inventory of home adaptations

   List and provide detailed information regarding any home adaptations already present in the applicant/member's home.

Section IX – Household Information

This section compiles information regarding the applicant/member's household. There are two (2) questions in this section. Each question must be answered, **do not** leave blank or enter "N/A".

1. Recipient residing alone

   Check yes or no. If no, proceed to question #2. If yes, check the appropriate answer regarding assistance from others. If the applicant/member is receiving assistance from others, provide detailed information.

2. Household members

   Provide the name, relationship and age of the applicant/member's household member(s). Check yes or no if the individual is functionally able to provide care. If no, provide a detailed explanation in the "Comments" section. If yes, provide detailed information including the type of care provided and frequency in the "Comments" section.

Section X – Consumer Directed Option

This section compiles information regarding the member's choice to access services through the Consumer Directed Option. Both questions must be answered, **do not** leave blank.

1. Explanation of the Consumer Directed Option and Distribution of Enrollment Packet

   Check yes or no.

2. Choice of Consumer Directed Option

   Check yes or no

Section XI - Additional Service Information

This section compiles information regarding any additional services the applicant/member is receiving. There are five (5) questions in this section. Each question must be answered, **do not** leave blank or enter "N/A".

1. Hospital or nursing facility admissions

   Check yes or no. If no, proceed to question #2. If yes, provide the facility name, facility address, reason for admission, admission date and discharge date in the appropriate spaces.

2. Services from other agencies

   Check yes or no. If no, proceed to question #3. If yes, provide the type of service, agency/worker name, agency/worker phone number, agency address, frequency service provided and number of units in the appropriate spaces.

3. Traditional home health services

   Check yes or no. If no, proceed to question #4. If yes, provide the anticipated home health discharge date, type of service, visits (indicate per week or per month) and type of coverage (indicate Medicare, Medicaid, private insurance and/or private pay) in the appropriate spaces.

4. Summary

   Check certification or amendment/modification and summarize the applicant/member's assessment in the space provided. It must be signed and dated by the member(s) of the assessment team who completed this section.

5. Assessment team signatures

   Both members of the assessment/reassessment team must sign, provide their titles and date the MAP 351A form in this section.

6. Verbal Level of Care Confirmation

   This area documents the date and time of the verbal level of care confirmation. Enter the date the verbal level of care is received from the Peer Review Organization (PRO) and the time the verbal confirmation was received.

7. Assessment/Reassessment forwarded to case management provider

This area documents forwarding of the assessment/reassessment to the case management provider chosen by the member. If the same provider conducts the assessment/reassessment and is selected by the member to provide case management services this item and #8 may be left blank. If another provider is chosen by the member to conduct case management all areas in this item must be completed, **do not** leave blank or enter "N/A".

8. Receipt of Assessment/Reassessment by case management provider

This area documents the receipt of the assessment/reassessment by the case management provider. If the case management provider is different from the provider conducting the assessment/reassessment service, all areas in this item must be completed, **do not** leave blank or enter "N/A".

9. PRO Signature

This area is reserved for use by the Peer Review Organization. **Do not** complete this area.